BELLIACRES PEDIATRICS

PATIENT REGISTRATION

PATIENT#1 Last Name First MI

DOB Sex

PATIENT#2 Last Name First MI

DOB Sex

PATIENT #3 Last Name First MI

DOB Sex

PATIENT#4 Last Name First MI

DOB Sex

Mailing ADDRESS

(street)

(city) (state & zip)

PRIMARY PHONE ( ) -

PRIMARY PHARMACY

PRIMARY EMAIL

Who lives in this household?

CONTACT #1

Name

Relationship Lives with patient? Yes No

Address if different from patient

DOB Work phone

Home email Work email

Employer Occupation

CONTACT #2

Name

Relationship Lives with patient? Yes No

Address if different from patient

DOB Work phone

Home email Work email

Employer Occupation

May all contacts have access to the patient's records? YES NO

INSURANCE

Policy holder

Policy holder 's DOB Policy holder's gender M F

Insurance carrier

ID# Group#

If parents are divorced or separated, please fill out this section

Who has custody?

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's treatment? YES NO

Emergency Contacts (other than parents) (name and relationship)

1 Phone ( ) -

2 Phone ( ) -

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize payment under my insurance to be made directly to the physician providing these services. Whether or not your insurance company pays in full, a portion or no portion of your medical bill, is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. I acknowledge that I am responsible for unpaid or non-covered services.

Name:

Signature

Date:

Authorization to Release Information

I hereby authorize the physician to release information acquired in the course of examination and treatment of my child to the insurance carrier.

Signature:

Date:

Notice of Privacy Practices

A copy of BelliAcres Pediatrics Notice of Privacy Practices is available on our website, www.belliacrespediatrics.com, or at our office. Sign below to acknowledge review and receipt of these practices.

Sign:

Date: